

Note: Information is fully protected as a consumer health record under HIPAA, 42 CFR, Part 2, and G.S. 122C and contains individually identifiable health information. Disclosure of HIPAA protected information between providers and other covered entities may require consumer authorization. For consumers with substance abuse problems, written consent is required under 42 CFR, Part 2, for disclosure of confidential consumer information, unless such disclosure is permitted as an exception to the General Confidentiality Rule, including a medical emergency that poses an immediate threat to health and requires immediate medical intervention. Redisclosure of SA consumer information is prohibited under 42 CFR, Part 2.

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INSTRUCTIONS FOR STANDARDIZED CONSUMER STR INTERVIEW AND REGISTRATION FORM

<p>A. Consumer Name: Enter consumer's Last Name, Middle Initial, and First Name: <i>up to 15 characters.</i></p> <p>B. Consumer DOB: Enter consumer's date of birth, by month, day, and year: <i>8 characters.</i></p> <p>C. LME Name: Enter name of consumer's Local Management Entity (LME): <i>up to 12 characters.</i></p> <p>D. LME Facility Code: LME Facility Code may be completed as indicated by LME, or may be assigned by LME upon receipt of Form: <i>5 characters.</i></p> <p>E. LME Consumer Record No: LME Consumer Record Number may be completed as indicated by LME, or may be assigned by LME upon receipt of Form: <i>10 characters.</i></p> <p>F. Name of Provider Agency or LME Completing Form: Enter name of provider agency or LME completing this Form: <i>up to 15 characters.</i></p> <p>G. Medicaid Provider Enrollment No: Enter provider's Medicaid Provider Enrollment No., if applicable: <i>8 characters.</i></p> <p>H. IPRS Attending Provider No: Enter provider's IPRS Attending Provider No., if applicable: <i>8 characters.</i></p> <p>I. National Provider Identifier (NPI) No: Enter provider's National Provider Identifier (NPI) No., if applicable: <i>10 characters.</i></p> <p>J. Provider Consumer Record No: Enter provider's Consumer Record No: <i>10 characters.</i></p> <p>1. Entry Type: Indicate whether the Form is being completed for a STR Interview Only, a Consumer Registration Only, or both a STR Interview and Consumer Registration: (✓ <i>One</i>).</p> <p>2. Consumer Screening Date: Enter month, day, and year which represents the date that this consumer was screened for the current episode of care: <i>8 characters.</i></p> <p>3. Consumer Co. of Residence: Enter a county name (<i>up to 12 characters</i>) or valid county code (<i>3 characters</i>) for the state of North Carolina as listed in the CDW Data Dictionary.</p> <p>4. Consumer Enrollment in Medicaid: Indicate whether the consumer is currently enrolled in Medicaid: (✓ <i>One</i>).</p> <p>5. Screening Referral Source: Enter the appropriate Screening Referral Source code from the below for principal source that referred the consumer to the facility for the screening: <i>2 characters.</i></p> <p>01= Self or no referral 10= Family or friends 21= Other outpatient and residential non-state facility 22= State facility 23= Psychiatric service, General hospital 32= Non-residential treatment/habilitation program 41= Private physician 44= Nursing home board and care 46= Veteran's Administration 48= Other health care</p>	<p>60= Community agency 71= Court, corrections, prisons 80= Schools 99= Other</p> <p>6. Time Screening Began: Enter the time, in hours and minutes, using a 24 hour time clock format to indicate when the STR Interview began: <i>4 characters.</i></p> <p>7. Time Screening Ended: Enter the time, in hours and minutes, using a 24 hour time clock format to indicate when the STR Interview ended: <i>4 characters.</i></p> <p>8. Screening Method: Indicate whether the Screening Method was in-person face to face or by telephone: (✓ <i>One</i>).</p> <p>9. Name of Person Initiating Request for Services: Enter the name of the individual who is initiating this request for services, and the individual's relationship to the consumer. This individual may be the consumer who is making a direct request on their own behalf.</p> <p>10. Phone Number of Person Initiating Request for Services: Enter the phone number of the individual who is initiating this request for services: <i>8 characters.</i></p> <p>11. Brief Description of Presenting Problem: Provide a brief description of the consumer's presenting problem. (<i>Complete narrative</i>).</p> <p>12. Presenting Age/Disability Problem(s) of Consumer: Indicate the presenting age/disability problem(s) in order of importance. This item is not a determination of Target Population eligibility. (✓ <i>One box for first row for primary problem, and up to one box each for the second and third rows for secondary and tertiary problems</i>).</p> <p>13. Current Risk to Consumer Safety: Indicate the current risk to the consumer's safety using the five point Scale provided: (✓ <i>One box for each of three dimensions</i>).</p> <p>14. Need for Detox Services: Indicate whether the consumer is in need of detox services due to risk for acute alcohol or drug withdrawal symptoms. If "yes", check all symptoms that apply.</p> <p>15. Current Risk of Potential Harm to Self or Others: Indicate the current risk of potential harm to self or others using the five point Scale and the criteria provided: (✓ <i>One box for each of two dimensions</i>).</p> <p>16. Triage Severity of Need Determination: Indicate the consumer's Triage Severity of Need Determination of Emergent, Urgent, Routine, or Non-Threshold Clinical Need: (✓ <i>One</i>).</p> <p>17. Consumer Referral after Triage: Indicate where the consumer is referred for response after Triage: (✓ <i>One</i>). <i>If Item No. 17 above is checked for "Community Resources", skip to Item 26.</i></p> <p>18. Initial Services(s) Recommended for Consumer: Indicate what initial services are recommended by the Screener for the consumer. (✓ <i>All that Apply</i>).</p> <p>19. Offer of Provider Appointment to Consumer: Indicate whether an appointment date and time (or crisis service) has been offered to the consumer by the provider: (✓ <i>One</i>). <i>If "Yes", complete Item 20. If "No" or "N/A", skip to 26.</i></p>
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| <p>20. Acceptance of Provider Appointment by Consumer: Indicate whether the appointment date and time that has been offered to the consumer by the provider has been accepted by the consumer: (✓ <i>One</i>). If "Yes", complete Items 21 – 22. If "No", skip to Item 26.</p> <p>21. Provider Agency Referred to and Location: Identify the provider agency and location that the consumer has been referred to.</p> <p>22. Phone Number of Provider Referred to: Identify the phone number of the provider that the consumer has been referred to.
<i>Complete Item 23 only for Enhanced Benefits Service or Crisis Service, based on appointment or actual receipt of a Crisis Service. (Enter date and time)</i></p> <p>23. Appointment Date and Time Scheduled: Enter the provider scheduled appointment date and time in a 24 hour format, or the date and time that the crisis service was initiated: <i>8 characters followed by 4 characters.</i></p> <p>24. How Provider was Chosen: Indicate how the provider was selected. (✓ <i>One Only</i>).</p> <p>25. Why Provider Was Chosen: Indicate how the provider was selected. (✓ <i>All that apply</i>).</p> <p>26. Accommodation of Special Consumer Needs: Indicate any accommodation made to meet special needs of the consumer. (✓ <i>All that apply</i>).</p> <p>27. Consumer's Primary Medical Provider: Enter the name of the consumer's primary health care provider – physician, physician's assistant, or nurse practitioner.</p> <p>28. Special Arrangements for Services Access: Indicate any special arrangements made for services access. (✓ <i>All that apply</i>).</p> <p>29. Ethnicity: Indicate the consumer's Hispanic origin: (✓ <i>One</i>).</p> <p>30. Race: Indicate the consumer's primary racial affiliation: (✓ <i>One</i>).</p> <p>31. English Proficiency: Indicate whether English is spoken and understood by the consumer at a relatively high level of proficiency, e.g. no interpreter is required: (✓ <i>One</i>).</p> <p>32. Primary Language: Indicate the language spoken and/or understood by the consumer: (✓ <i>One</i>).</p> <p>33. Gender: Indicate the consumer's sex: (✓ <i>One</i>).</p> <p>34. Veteran Status: Indicate whether the individual has served on active duty in the armed forces of the U.S., including the Coast Guard: (✓ <i>One</i>).</p> <p>35. National Guard or Military Reserve: Indicate whether the consumer or an immediate family member (parent, grandparent, sibling, spouse, partner, child, or other significant person in the family constellation) has served in the National Guard or Military Reserve in support of Operation Iraqi Freedom (OIF) or Operation Enduring Freedom (OEF): (✓ <i>One</i>).</p> <p>36. Consumer's Street Address/City/State: Enter this information for consumer as appropriate and available.</p> <p>37. Consumer's Phone Number: Enter this information for consumer as appropriate and available.</p> | <p>38. Consumers' Mailing Address/City/State/Zip Code: Enter this information for consumer as appropriate and available.</p> <p>39. Consumer's Legal Guardian (if applicable): Enter this information for consumer as appropriate and available.</p> <p>40. Phone No. of Consumer's Legal Guardian (if applicable): Enter this information for consumer as appropriate and available.</p> <p>41. Emergency Contact Name and Relationship for Consumer: Enter this information for consumer as appropriate and available.</p> <p>42. Phone Number of Emergency Contact for Consumer: Enter this information for consumer as appropriate and available.</p> <p>43. Consumer Unique Identifier: Enter consumer number: <i>10 or 11 characters.</i> The unique identifier consists of the first three characters of last name, 1st character of first name, 6 character birth date, and an identifier if more than one LME consumer has the same unique identifier number.</p> <p>44. Type of Agency Hosting STR: Indicate type of agency hosting STR. (✓ <i>All that apply</i>).</p> <p>45. Name of Qualified Professional (QP) conducted STR Interview: List first and last name of the QP staff who conducted the STR Interview.</p> <p>46. STR Staff Qualifications: Indicate the QP qualifications by disability group. (✓ <i>All that apply</i>).</p> <p>47. STR Staff Area Code, Phone No., & Extension: Enter the area code, phone number, and extension of the provider staff who conducted the STR Interview.</p> <p>48. Date Form Submitted to LME: Enter the date by month, day, and year that this form was submitted to the LME.</p> <p>*****</p> <p style="text-align: center;">👤 CONSUMER REGISTRATION FOR ENHANCED BENEFITS PROVIDERS 👤</p> <p>49. ⑥ Date of Consumer Service Initiation: Enter the date by month, day, and year that services to the consumer were initiated: <i>8 characters.</i></p> <p>50. ⑥ Consumer Social Security Number: Enter consumer number: <i>9 characters.</i> This number is needed for cross-referencing with the Department's Common Name Database Services (CNDS). A consumer SSN will not always be available to a provider when completing this Form.</p> <p>51. ⑥ Consumer Medicaid Number: Enter consumer number: <i>10 characters.</i></p> <p>52. ⑥ First and Last Name of Provider Staff submitting this Form to LME: Enter first and last name of staff submitting this form to LME: <i>up to 24 characters.</i></p> <p>53. ⑥ E-Mail of Provider Staff submitting this Form to LME: Enter e-mail address of staff submitting this form to LME: <i>up to 24 characters.</i></p> <p>54. ⑥ Area Code and Phone No.: Enter area code and phone number of staff submitting this form to the LME: <i>10 characters.</i></p> <p>55. ⑥ Date Form Submitted to LME: Enter date by month, day, and year that this form was submitted to the LME by the provider: <i>8 characters.</i></p> |
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